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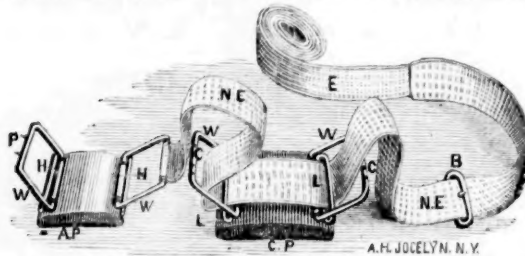
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LECTURE IV.

DISEASES OF THE EYELIDS.—THE LACHRYMAL APPARATUS.

Blepharoplasty.—A partial or total loss of the eyelids may be produced by ulceration, by burns, by the removal of cancer, by wounds. The mode of repairing these deficiencies is by transplantation of neighboring skin. The entire lid may be formed in this way, but can only serve as a mechanical protection to the eyeball: the want of fibro-cartilage, as well as of the muscular apparatus, makes the substitute a very inferior one.

Sometimes not even this degree of relief can be afforded, as in a case which I saw a few months since. A young man, fifteen years old, had been burned several years previously; all the left side of his face had suffered severely, the auricle was gone, and all the skin had been destroyed. His features were dreadfully distorted by the contraction of the cicatrices; but his greatest distress was on account of the state of the eye. The lids had been partially burned off, and now their mucous lining was completely turned out and converted into a mass of fungous granulations. The eyeball was in continual irritation, and could not be covered by the lids. To obviate the suffering caused by dryness of the exposed globe, he wore upon it a bit of linen smeared with simple cerate. There was no healthy skin near enough to furnish flaps for new eyelids. I advised extirpation of the eye, for the cornea was hopelessly opaque, but he would not accept the proposal.

Cases of *partial* destruction of the lids admit of much relief. The same operations are practised as for ectropium, but the demands on the adjacent skin are more extensive. At the present time such operations are frequently called for to correct the deformities resulting from gunshot wounds. Oftentimes the eye has been destroyed, and the patient wants to be enabled to wear an artificial eye. There is usually adhesion of the soft parts to the bone, and, in operating for the formation of a new eyelid, extensive incisions are needed to loosen the skin from its attachments. But in making the flaps, whether by sliding or transplanting or both, they must be fitted in anticipation of the re-establishment of adhesion to the bone. It is of great importance to spare all that may be left of the conjunctiva and of the ciliary border. I cannot go into details of the flaps to be made, because every case has to be operated upon after a special plan suitable to its peculiar condition. Neither can you always determine the best plan until the adhesions have been liberated, or until after the removal of parts requiring excision; then you see how great a breach is to be provided for.

Ankyloblepharon.—The edges of the lids sometimes adhere to each other in consequence of burns, wounds, ulceration, and even from obstinate blepharitis ciliaris. A preternatural cohesion is sometimes congenital. The congenital form presents a furrow to mark the palpebral fissure, and only a thin membrane unites the ciliary border. The accidental adhesion may be more or less extensive.

That contraction of the palpebral opening which follows long continued granular conjunctivitis, is not what I now allude to. That does not occur by adhesion of the tarsal margins, but by shrinking of all the palpebral tissues. It has been christened by the formidable name of blepharophymosis.

Its relief by elongation of the palpebral fissure I have already described. Ankyloblepharon is a rare deformity, and is to be overcome by dividing the adhesion with a bistoury, and then to keep the edges apart by dress-

ing the raw surfaces with collodion, or by passing a probe between them once or twice daily.

Symblepharon.—This is preternatural adhesion of the palpebræ to the globe. It is the effect of burns, as by caustic lime, melted metal, etc.; very rarely of simple ulceration. The cure of this condition is difficult, and its prevention is also difficult when the opposing conjunctival surfaces have been burned. If the eyelid is adherent to the globe by a broad surface, it cannot be permanently separated. If the adhesion be columnar, it is easily divided by the scalpel, and by frequent touching with nitrate of silver the surfaces may cicatrize without uniting. Another mode of operating is to pass a thread or wire through the adhesion near the cul de sac: let it be worn for a few days so as to form a permanent perforation, and then cut through the uniting band by tightening the ligature every day.

I recently saw a man who, nine years ago, had been hit in the eye by a bit of red-hot iron struck off the end of a rod by a blacksmith's hammer. The piece was about an inch long. It destroyed the eye, and produced perfect adhesion of the palpebræ to the eyeball and to each other. The ciliæ had been destroyed, and nothing was to be seen but the smooth external surface of the eyelids, continuous with the skin of the face. The destruction had been so complete that he suffered no other annoyance than the loss of the eye.

Pediculi.—Occasionally lice find a lodgment on the ciliæ. They are usually the body lice, *pediculi pubis*. Their ova will be found on the lashes like beads on a thread. I mention the fact to guard against confounding them with ordinary ophthalmia tarsi. Dalrymple gives a plate which shows their appearance very well. Mercurial ointment applied for a few days destroys them.

LACHRYMAL APPARATUS.

Anatomy.—The lachrymal apparatus consists of a secreting and an excreting portion. The secreting portion is composed of the lachrymal gland and the conjunctiva: the excreting portion consists of the puncta, the canaliculi, the sac, and the nasal duct. The lachrymal gland occupies a shallow fossa in the frontal bone at the upper and outer angle of the opening of the orbit. It is enveloped by the oculo-orbital aponeurosis, and is about the size of a large bean. It is concavo-convex, and is divided by a deep fissure into a greater and less portion; the latter sometimes called the accessory gland. Its structure is conglomerate like the salivary glands. It is constructed of acini lined by epithelium and enveloped by capillaries, the whole consolidated by fibrous tissue; the acini communicate with small tubules, which in turn unite into efferent ducts six to ten in number. These open into the external part of the superior cul-de-sac of the conjunctiva by minute orifices. The orifices are usually out of view, even when the lid is everted, but I have sometimes exposed them in persons whose eyes were very prominent. The secretion of the gland is water holding in solution about one per cent. of chloride of sodium and albumen. Moisture is also furnished to the eye by the conjunctiva. The excretory apparatus begins at the puncta lachrymalia, which are directed against the eyeball, and can be seen only by everting the lids. A fine probe entering the punctum will for a line take a vertical direction, and then passes horizontally for a quarter of an inch along the canaliculus until it enters the lachrymal sac. The canaliculi are lined by mucous membrane having a pavement epithelium, and they usually open by a common aperture into the lachrymal sac. The lachrymal sac is simply the expanded extremity of the nasal duct. It is about five lines long and two lines broad. Its walls nearly touch each other in the cadaver, and its cavity is a mere slit. It rises about two lines above the opening of the canaliculi. It is covered in front by the tendon and fibres of the orbicularis muscle, as well as by the skin; behind it are the fibres of the tensor tarsi. It lies in a groove channelled for it in the lachrymal bone. Its mucous lining is thick, covered by

cylindrical epithelium, and studded with both simple and racemose follicles. The nasal duct is assumed to begin at the commencement of the bony canal through the superior maxilla. It is about half an inch long, and terminates in the inferior nasal fossa under the inferior turbinated bone, about three-quarters of an inch behind the orifice of the nostril. At the beginning of the nasal duct is a fold of mucous membrane, making an imperfect valve. At the middle of the duct another is sometimes found, as described by Hirschfeldt. Its inferior extremity is always overlapped by a fold of Schneiderian membrane, and the orifice is a mere slit. It is very difficult to penetrate the nasal duct from the nostril. The lining membrane of the lachrymal sac and nasal duct is a fibro-mucous tissue. It serves as periosteum to the bone which it covers, and also secretes a thick glairy mucus. Its mucous follicles are both simple and racemose, the latter quite abundant. Its epithelium is cylindrical. The most recent investigators do not admit the existence in it of ciliated epithelium.

Physiology.—Under ordinary circumstances the lachrymal gland takes little part in the lubrication of the eye: the conjunctiva furnishes moisture enough for this purpose. This is proved by the sufficiently moist state of the eye in cases where the lachrymal gland has been extirpated. So, too, excretion by the lachrymal passages is ordinarily very small in quantity, because evaporation suffices to carry off the excess of fluid. This is shown by what occurs when the sac and duct have been obliterated. When, however, the surface of the eye is irritated by wind, smoke, dust, or foreign particles, the lachrymal gland pours out an abundant flow: the derivative apparatus comes into active play, and is often taxed to more than its capacity. The manner in which tears are conveyed away has long been controverted. A great variety of theories have been broached, and many of them contradictory. Suction, aspiration, capillary attraction, etc., have been invoked, but unsatisfactorily. The real difficulty has been in the want of exact knowledge of the action of the muscles of the eyelids. A very careful study of this subject has been made by Dr. Henke, and is reported in the Archives for Ophthalmology, Band iv., Abth. 2, page 70, 1858. The essential points are as follows:—When the eyelids are open the lachrymal sac is shut; its walls lie in contact. The eyelids close by contraction of the palpebral portion of the orbicularis, whose fibres are inserted into the internal palpebral ligament and into the anterior wall of the sac. As the lids close, the internal palpebral ligament is made tense and lifted forwards, and the lachrymal sac is opened. The same action lifts the lower lid a little off the globe at the inner canthus, forming as the tears are pushed along a lacus lachrymalis. The puncta are bathed in the fluid, and by the same muscular action of closing the lids it is forced into them and onwards through the canaliculi into the opened sac. The orbicularis relaxes, the lower lid drops, the upper lid is lifted by the levator palpebrae, and then the tensor tarsi comes into play. It lies behind the sac, and is inserted by two horizontal processes into the border of the lids as far as the puncta. It contracts at the same moment with the levator palpebrae, prevents regurgitation by the puncta, and forcibly closes the sac, pushing the collected fluid downwards into the nasal duct. The removal of tears is thus the result of muscular action. It seems to me that the valve which covers the inferior extremity of the nasal duct may aid the conveyance of tears by preventing the entrance of air, as by contraction of the orbicularis the sac is opened: a partial vacuum will occur in the cavity of the duct and sac, which will invite the tears to enter the puncta at the same time that they are propelled into them by the closing lids.

Diseases.—The lachrymal gland is rarely the seat of disease; it has been known to become scirrhous, and it is sometimes acutely inflamed. At M. Desmarre's clinique I saw a patient with acute inflammation of both lachrymal glands. Symptoms of its influence will be the situation of the swelling, the redness of the conjunctiva, and the ten-

derness on pressure. Treatment mildly antiphlogistic. It is in the derivative apparatus that the great trouble arises, and such derangements are abundant. The symptom of which patients complain is, that tears stand in the eye or overflow the cheek—*epiphora*. This symptom is common to all lachrymal diseases. But it would be an error to regard epiphora as always evidencing lachrymal disease; and it is equally erroneous to suppose that, when the name epiphora has been pronounced, the real disease has been discovered, and it only remains to order some drops for the eye. Much of the discredit and dissatisfaction in treating lachrymal diseases arise from slovenly diagnosis. Patients may have epiphora because of palpebral conjunctivitis: it excites an undue secretion of tears, while there will be no obstruction of the escape passages. On the other hand, chronic influence of the lachrymal passages provokes palpebral conjunctivitis, and there will then be both an excess of secretion and obstruction to elimination. It becomes necessary to examine both the conjunctiva and the lachrymal passages to determine the cause of epiphora. There may be defects in the puncta, in the canaliculi, in the sac, and in the duct.

The puncta are often displaced. They fail to come in contact with the globe, but look upwards or forwards. This eversion results from laxity of the eyelids, from paralysis of the orbicularis, from chronic inflammation of the tissues of the lid, from growth of tumors. In old persons, the skin becoming loose and the orbicularis feeble, the puncta are not held in contact with the eye. This is specially true of the lower lid. If tears prove annoying, the puncture may be enlarged by slitting it up, and if the lid be still too loose to force the tears away, a wedge-shaped piece may be excised from the lid to shorten it. The piece may be removed from the middle or outer portion of the lid, the base of the wedge being at the ciliary border. Thickening of the lid from ophthalmia tarsi, lippitudo, or conjunctivitis, often pushes off the puncta. Treatment consists in slitting the lower canaliculus up to the caruncle, and endeavoring to reduce the thickening of the lid by proper applications. The latter endeavor may be unsuccessful because of the inveteracy of the malady, but the first expedient will afford much relief. Simply slitting the canaliculus is not always enough; the posterior wall of the tube may need to be removed with scissors, and if eversion be great, a bite taken out of the conjunctiva adjacent to the canaliculus. This will tend to turn the new openings inwards as cicatrization occurs. Eversion of the puncta from tarsal tumors will be relieved by their removal.

The canaliculi may be obstructed. As a rare occurrence, a minute chalky concretion deposited from the tears blocks them up. The dacryolith will be felt by the probe, and may be cut out with a cataract knife. Mr. Dixon observes that a cilium sometimes gets into the punctum. The canaliculus may be narrowed at some point by stricture. This will be discovered by passing a fine probe. For such an exploration, I prefer Bourman's fine probe-pointed director to the silver probe. It is stiffer, being of gilded steel and tapering. It may be used as a dilator. Such strictures yield to a few introductions of probes. Mr. Bowman proposed to divide them within the tube by a minute sheathed knife, on the same principle as the urethrotome. If a stricture be hard, or if the patient be disinclined to the repeated passage of probes, I have no hesitation in laying open the canaliculus in the usual way. This little operation is a cure for many of the causes of epiphora, and is preliminary to treatment of almost all cases of lachrymal disease. It is not always easy to do it satisfactorily, because of the forcible shutting of the eyelids. One may not have an assistant to call upon; it is desirable, therefore, to have one hand free to control the lids, while the other does the operation. The use of a fine grooved probe and a cataract-knife requires both hands. The operation may be done with fine scissors, but the canaliculus cannot be opened to any desired extent, because of the rapid increase in thickness of the blades. It is easy with scissors to divide the punctum and vertical portion of

the canaliculus, but the horizontal part cannot be extensively divided. It is desirable to open the tube up to the caruncle and even into the lachrymal sac. The easiest way to do it is by a fine probe-pointed bistoury. I have used two sorts, one whose blade is very narrow, and which cuts after it has been pushed into the canaliculus by elevating the handle while the point is fixed as a fulcrum. I have also had another knife made in which the blade is much broader, and juts over the probe point in a rounded shoulder; this cuts as it is pushed along. I find both these forms useful. In doing the operation, the patient should sit in a low chair facing the light, the surgeon standing behind and supporting his head. If the lower canaliculus is to be opened, the fingers of one hand must draw the ciliary border outwards and downwards, to expose the punctum and keep the eyelid tense. The patient should be directed to look upwards and outwards. With the other hand the probe point of the knife is entered vertically into the punctum, and when fairly engaged, the handle brought down to the horizontal direction, and the blade pushed rapidly along the canaliculus as far as it can be made to go. With the broad-bladed knife the section is now completed; with the narrow-bladed knife the handle must be lifted up while the point is held fixed, and in this movement the canaliculus will be laid open. If the patient do not convulsively shut the lids, the narrow-bladed knife will do the operation very well; but if the lids are tightly squeezed together, the blade which cuts as it is pushed, is more certain to do the work.

The next day after the operation a probe must be run through the cut to prevent it from uniting, and the same thing may be needed a second time. This operation does not disfigure the face, and is not open to any physiological objections. Tears pass off as readily by the slit as by the natural punctum.

There are many cases in which it is indispensable to divide the canaliculus through its whole length: as for eversion produced by chronic conjunctivitis, or by ophthalmia tarsi; also, to introduce the largest sized probes into the ductus ad nasum. I am satisfied that no inconvenience results from this free division in any case, and that a less extensive division is sometimes very insufficient. I shall allude to this point again.

Original Communications.

CAN SYPHILIS BE PROPAGATED THROUGH VACCINATION?

By W. C. OTTERSON, SURGEON U.S.V.

THE phenomena of inoculation and of the more modern and much improved practice of vaccination, have been pretty closely studied by the profession in all its phases. Much discussion has arisen in regard to the powers of transmitting certain diatheses and diseases by the means of vaccine disease. Although the profession have been a unit on the *desirableness* of procuring good and healthy virus, yet there has been, and still is a large and respectable class, who contend that the discriminating powers of nature reject what may be bad, and carry *only* the healthy constituents of the virus, and that the virus will pass through a system impregnated with vices, and leave them to carry on their work where found, without doing more than sometimes stirring up the morbid principle to active operation. Others argue that many diseases can be, and are transmitted by this means, and that the various forms of scrofula, and other constitutional taints, may be ingrafted by vaccination. Which party in the controversy carries the greatest weight, I am unable to say. My own opinions may be gathered from a perusal of this article. I propose to introduce to the notice of the profession a series of phenomena in connexion with vaccination, to which my attention has just been called, entirely new to me.

I.—On the fifteenth day of June, 1862, Lieut. H., of the 18th Regiment Ind. Vol. Infantry, presented himself with the following history of his case: Age twenty-six, married, always been in good health, been in the service of the U.S. about a year, was vaccinated on March 20th; no effect was noticed until about the tenth of May; during this period the regiment marched about three hundred miles; the weather was very rainy, the mud and streams very deep. No particular difficulty was experienced. The arm at the end of forty days began to inflame, attended with scaly patches over the chest and arms. At the same time a painful condition of the joints developed itself, beginning with the shoulder and arm of the side on which the virus was introduced, extending to the knee-joints and tendons; and has frontal headache, *increase of pain in the afternoon* and fore part of the night, while it passes off towards morning. The cervical glands are enlarged and tender. Throat sore, having a flabby congested condition of the posterior fauces, but no ulceration. Irritation in nearly the whole spinal column. Bowels regular. Appetite varying. Tongue clean on edges, in the centre covered with light brown fur. Pulse 90 and irregular, indicating a morbidly excitable condition of the nervous system. Has a tingling numb sensation in the right arm and leg "as though it were asleep." Sight is blurred; has ocular spectra. The cicatrix on the arm is irregular in shape, and the size of an old shilling; it has a dark unhealthy look, and an areola extending an inch and a half in diameter, the color as though it had recently been painted with a weak tincture of iodine.

II.—Richard Taylor, age twenty-seven, private in the 18th Regiment Ind. Vol. Infantry, was vaccinated about the middle of March; had always been healthy up to this time; had no rheumatic trouble. On the sixteenth of June has still on the arm an ulcer with everted edges, the size of a quarter dollar, involving in depth the true skin and part of the subcutaneous areolar tissue; the surface is very red, with exuberant granulations that bleed upon the least touch; arm is quite painful. Three months have now elapsed since the virus was inserted; it remained latent thirty-five days before the arm began to inflame. At the same time he was seized with a painful affection of the left hip, knee, and leg, with numbness, always increased in the after part of the day and fore part of the night, on account of which can sleep very little till after midnight. Spinal irritation in the cervical and upper dorsal vertebrae. Had no fever; appetite poor; has lost flesh; has taken no medicine; difficulty appears to be confined to the left side; copper-colored spots on legs, without being characteristic.

III.—Seth Wagner, aged twenty-nine, private 18th Regiment Ind. Vol. Infantry, vaccinated with the same virus that was used in the other cases. Six weeks elapsed before any evidences of its taking appeared, and when it did, it was attended with painful condition of hip and shoulder, soon followed by scaly patches on chest. Has never had rheumatism. No treatment. IV.—Capt. Jones, 18th Regiment Ind. Vol. Infantry, vaccinated about 20th March, but showed no signs of taking till first of May. About May 15th was taken with painful affection of the knee, ankle, arm, and shoulder; some febrile action; a little tendency to intermit. Was treated by the Regimental Surgeon by a mercurial purge, followed by quinine; took colchicum without improvement. Improved rapidly on the use of iodide of potassa, the latter having produced its characteristic eruption; pains in bones, and frontal headache increased at night. V.—John M., aged twenty-two, single, 18th Regiment Ind. Vols. Infantry, vaccinated about March 20th, began to feel his arm inflamed on May 8th; health had always been good. Arm was healing, when lameness began in shoulder, elbow, knee, and wrist of same side; no increase of pain in after part of the day. Has improved on the use of iodide of potassium. VI.—Harvey S., good constitution and health previous to the development of symptoms following the vaccination, its latent stage being about the same as the others. The pains began at the

time the arm healed; elbow, knee, and wrist affected; increase of pain in the after part of the day. Had no eruption on the skin, or sore throat. VII.—W. M.—Same history. Pains began at the time the arm healed; scaly eruptions on the body; pains more severe in the after part of the day; frontal headache; never had rheumatism before. VIII.—B. C.—History nearly same. Frontal headache increased decidedly in the after part of the day; enlargement of the cervical glands; has tubercular eruption on the skin; throat sore, but no ulceration; the cicatrix on this man's arm is about the size of a dime, elevated about the thickness of a quarter dollar; the surrounding surface is red, and contains fluid, probably grumous blood; this arm never ulcerated, this being the extent of the local effects. IX.—J. M.—Same regiment, history much the same. Arm was healing when pain and stiffness began in shoulder, elbow, and wrist; no increase of pain in after part of the day; no eruption or sore throat; has improved on the use of iodide of potassa, though has not taken it long enough to get its full effects.

The history of the vaccine virus, so far as can be obtained, is, that it was taken from a man who had been in hospital, and while convalescing from typhoid fever and pneumonia, was vaccinated. The scab taken from his arm was the article used in these cases, all of which were undoubtedly spurious. The man went home on a furlough, and was absent during the incubative stage of his vaccine. He had been vaccinated when a child. The disease was tardy and irregular in its progress, and he had, after it healed, and before the march was made, some rheumatic trouble, almost entire loss of power in the arms; had no skin disease or night pains. Another interesting fact is that out of three hundred cases that were vaccinated only eighty were affected with the vaccine, all of whom had nearly the same train of symptoms as described. In most of these cases there was sore throat, but nothing to indicate it was specific; many of them had skin disease, none of them but what were of such a mixed character that they threw little or no light on the subject: some were scaly, some were vesicular. The onus of this morbid action has been on the fibrous structures, the nervous system, and the skin; sometimes the mucous membrane and glandular system have been involved, but the rheumatic element has been the predominating one in the train. The question arises—Had the man chancre from whom this virus was taken at the time the vaccine disease was running its course, contracted during the incubation of the vaccine? If so, did these diseases run their course in his system *pari passu*? What influence, and how far would the march, exposure, and fatigue, these men suffered, modify, retard, or alter the vaccine disease? Strict inquiry was made in all these cases in regard to their having the primary disease; they aver they never had, and from their answers to questions indicate they had never had any secondary symptoms, a condition of things that would hardly obtain among men who had been treated by a country surgeon without some exceptions. From the evidences before us, are we justified in the conclusion that these cases were inoculated with matter taken from a subject who, at the time the disease was in progress, was suffering with chancre, and thus call this *syphilitic rheumatism*, the type of the disease being syphilitic instead of vaccine? The development of secondary and tertiary symptoms, as to time, would seem to indicate that such was the case. If this is the fact, the constitutional vices can be transmitted from a diseased to a healthy subject by means of vaccination. The child who is sent into this breathing world as the last act of a mother who has phthisis or cancer, being vaccinated, that virus, on being introduced into the arm of a perfectly healthy subject, may it not receive with the vaccine disease the seeds of an insidious malady that, under proper circumstances, may develop the same disease that obtained in the woman from whose child this virus was taken? These are grave and important questions, and I know will be answered most promptly in the negative by many of our "first men," but unfortunately

our "first men" do not always hold to the same theory, and, therefore, sometimes must be in error. The men who had this disease from sore arms were nearly all the cases of rheumatism in the regiment. None of them had been so affected before. There were no cardiac complications so far as my investigations extended. In the treatment of these cases the iodide of potassa was the only remedy that offered any relief—this almost without fail did. As soon as the system began to feel its influence the patient began to improve. As yet the time has been too short to know what the ultimate results of treatment may be. So far as my recollection and reading extend this whole subject is one that is as new as novel, although the subject of syphilitic inoculation has been tested in all shapes and forms. The complication, as suggested in this paper, is one that I have not met with: there is one thing very evident, that in these cases there were no traces of the *genuine vaccine* disease, and it is not at all probable that these were anything more than *poisoned wounds*. What was this poison if not syphilitic? And if syphilitic, why is it that these patients were not all affected in the same manner? Record answers this partly, who says, "All the reported secondary symptoms are far from being specific; but the infection by the venereal virus may produce in the system disturbances, lesions, and the development of morbid symptoms resembling those which another non-specific cause might also have caused." In almost all these cases there was sore throat (but not ulcerated), glandular enlargements, particularly the cervical; pain increased in the after part of the day and evening. In some, frontal headache; in many, eruptions of various kinds on the skin. In the regiment there were very few cases of rheumatism besides those described. If the crude and incomplete relation of these cases gives rise to investigation and inquiries tending to throw light on this subject, or demonstrate what may be known as a fact, I shall be glad to have made the inquiry—Have we syphilitic rheumatism from the causes indicated? Since the above was written several cases of ophthalmia from the same regiment have presented themselves, in all of whom I have found the iris involved. I have ordered some of these men in hospital to be treated by different agents, the results to be carefully noted. If possible, at some future period, I will give to the world the results.

HEADQUARTERS, ARMY SOUTH WEST,
BATESVILLE, ARK., JUNE, 1862.

ERYSIPELAS,

AS IT OCCURRED IN HOSPITAL NO. 10, NASHVILLE, TENN.

By DEWITT C. DAY, M.D.,

ACT. ASST. SURGEON, U.S.A.

In November last Medical Director Swift established an Erysipelas Hospital in the City of Nashville, in which I acted as Assistant Surgeon.

The extensive lecture halls of the Medical Department of the University of Nashville were used as wards for the sick. An abundance of fresh air was thus secured to the patients, the windows permitting of free ventilation both at top and bottom.

We have had, since the establishment of the hospital, upon an average about seventy-five patients daily in the wards. These patients were sent from General Hospitals in this city, and from camps in its immediate vicinity.

It will thus be seen that our opportunities for observation have been by no means meagre, and with the hope that some member of the profession will still further investigate the ideas we advance, we have been induced to offer the following remarks for publication:—

Recognised as erysipelas has been from the early eras of medical science, it is a subject of astonishment that, at the present day, so little is known in regard to its real nature, causes, and treatment.

Nosologists thus far have not been able to give it a definite classification; some place it with the *Exanthemata*, others with the *Phlegmasia*. Linnæus chose erysipelas as

the prototype of the eruptive fevers, but denied its contagiousness, although in many respects it resembles measles, scarlatina, and small-pox. That the disease depends upon a specific poison, is scarcely susceptible of doubt, but of the real nature of this poison, where and how generated, we are yet ignorant.

A large majority of the patients, coming under our observation, were stricken in hospital while laboring under, or convalescing from other diseases, most generally measles, chronic diarrhoea, and typhoid fever. It seems to be a rule, not, however, without exceptions, that the disease delights to seize and prey upon patients in whom, from some cause, the *vis vite* has become enfeebled.

As to its contagious or non-contagious nature, the profession is yet undecided. Our observations, so far as they go, indicate its contagious nature. But few of the nurses employed when the hospital was first established, escaped. Those nurses who had been detailed into hospital as unfit for field service, with but few exceptions, fell victims to the disease. Robust healthy men most generally escaped; but two or three of this class took the disease. In erysipelas, how far the general law obtains, that all diseases having a tendency to putridity induce a corresponding condition in the bodies of those predisposed to be so affected, and in contact with such diseases, we know not, but believe it to be highly probable. One fact we think is pretty firmly established, that OCCELESIIS favors the development of the disease.

We have by careful examination of cases in hospital endeavored to definitely settle what tissues were really affected in this disease. Many maintained, and no one supported the idea more strenuously than Mr. Lawrence, that the skin and subjacent cellular tissue were the true and only seats of the disease, and that the peculiarities of this inflammation were mainly due to the modifications in structure of the parts affected. We believe that much is true in regard to the last proposition, but observations do not permit us to give assent to the first. Ocular demonstrations, made upon several hundred cases, prove satisfactorily to our mind that, in a large majority of cases, the disease first makes its appearance upon the mucous membrane. The analogy existing in the forming stage of erysipelas and the idiopathic eruptive fevers, is quite striking. It will be remembered that the eruption of measles and scarlatina always appears upon the mucous membrane in advance of the external manifestations. In a majority of cases the same phenomenon may be demonstrated in regard to erysipelas.

Mr. Lawrence states, that facial erysipelas but seldom involves the mucous membrane of the air passages. In the cases coming under our observation the reverse obtains: most generally the patients are affected with a cough and sore throat. An examination shows the fauces to be in an inflamed condition. Finally, the inflammation emerging, curls over the lip or ala of the nose, and the true skin becomes involved.

It is acknowledged that, in many respects, the skin and mucous membrane are homophytic structures. In some of their functions they are nearly allied; and to the diseases that attack one, the other is peculiarly susceptible. The analogy existing between the skin and the mucous membrane is much more striking than that existing between the skin and subjacent cellular tissue. If this be true, it is not strange that the disease should select as its seat either one of the above tissues. That it attacks the mucous membrane primarily in a majority of cases, may be accounted for upon the principle of its greater susceptibility to such attacks.

It has been stated that the inflammation occurring in mucous membranes during an attack of erysipelas, has but one characteristic sign of the disease under consideration, namely, redness. We are told that ulceration is a frequent sequence, but that swelling and vesications are absent. It needs but a little reflection upon the anatomical structure of the two membranes, to give a satisfactory solution to the question. The absence of vesications upon the mucous

membrane does not prove that it is not affected with true erysipelatous inflammation. Vesications rarely occur upon the skin, and then only in the mild form of the disease. So far from being essential to the disease, they are mere mechanical products, consisting of effused serum held down by the epidermis. Hence, when we have a mild attack involving only the true skin, vesications occur, but in all attacks involving the subcutaneous areolar tissue, effusion of serum takes place in the meshes of that tissue, and oedema is the result.

The absence of swelling in the mucous membrane may be readily accounted for upon the principle, that the mucous membrane rapidly throws off the serum, the product of inflammatory action, from its surface. In an attack in which the skin only is involved, we do not have swelling, because this depends upon an effusion in the areolar tissue. Hence, in an inflammation occurring in a mucous membrane, and not involving the submucous cellular tissue, we should expect, *a priori*, that the effused serum would be readily thrown off, thus preventing infiltration and consequent oedema. Should the inflammation, however, extend down and involve the submucous areolar tissue, which is sometimes the case, we would undoubtedly have swelling, which we have repeatedly witnessed. We have seen patients in this hospital almost asphyxiated, so great was the infiltration in the submucous tissue.

Mucous membranes may be affected not only primarily, but involved by the extension of the inflammation from the true skin. Dr. Bouling has clearly demonstrated the existence of erysipelatous bronchitis, pneumonia, and diarrhoea, occurring in patients in this hospital. I have seen the same diseases attack patients laboring under erysipelas under circumstances that could not admit of a rational doubt as to the individuality of the complication. The reason of this is susceptible of easy explanation. If we have established the fact that mucous membranes may be attacked with erysipelatous inflammation, it would follow as a consequence that the vesicular mucous membrane of the air passages, or the intestinal mucous membrane, would as readily take on erysipelatous inflammation as the fauces.

The characteristics of a common case of pneumonia will, for the most part, apply to a case of erysipelatous pneumonia, except that in the latter the symptoms are more aggravated from the beginning of the attack.

A soldier was shot in the arm at the battle of Stone's river. The arm was amputated near the shoulder-joint. Erysipelas took place in the wound, and he was admitted into this hospital. The patient was over six feet high, with quite a robust body. No symptoms of pneumonia upon admittance. He was placed in a ward kept at an equable temperature. He was treated with wine, a generous diet, and the topical application of the tincture of iodine. After the lapse of a few days the inflammation faded out in the vicinity of the wound, which was doing well, but spread rapidly over the chest and back. Suddenly, without any assignable cause, he was attacked with pneumonia. As the external signs of erysipelas faded out, so in the same ratio did the pneumonic manifestations increase. The disease would not respond to remedies, and the patient died. In this case the patient had not been exposed to alternations of temperature. He had been watched by a careful nurse, and the time that had elapsed since his admittance into hospital showed conclusively that previous exposure could not have acted as an exciting cause. The only rational solution of the question is that, as the erysipelas faded out upon the skin, it was re-kindled in the mucous membrane of the vesicular structure of the lungs.

Another patient was admitted into hospital with erysipelas of the forearm. An abscess, formed which was opened, and discharged about half a pint of matter. The erysipelas spread up the arm, finally over the whole of his back and chest, and nearly over the entire surface of the abdomen. He was treated pretty much as the former case. Notwithstanding the inflammation was so diffuse, the constitutional symptoms were by no means discouraging. He remained

in this condition several days. Finally, the redness began to disappear from the skin, and we congratulated ourselves that our patient would soon be well. This hope, however, was delusive. Pneumonia set in almost simultaneously with the decrease of the external symptoms, and the patient died. We might report numbers of cases of erysipelatous pneumonia occurring in this hospital, were it necessary.

What we have said in regard to erysipelas of the vesicular mucous membrane of the lungs, applies with equal force to the mucous membrane of the intestinal canal. We have seen great numbers of cases of erysipelatous diarrhoea as the result of the impress of the poison upon the gastrointestinal mucous membrane.

The diarrhoea resulting from erysipelatous poison, does not differ materially from the common diarrhoea, save in the obstinacy with which it resists the action of medicines. In cases occurring in this hospital we have employed the usual treatment for diarrhoea without any beneficial effect whatever.

Bronchorrhoea and otorrhoea are frequently present in attacks of erysipelas. Upon an average over half our patients have been thus affected, showing conclusively that the mucous membrane is very susceptible to the impress of this poison. We think it highly probable that the poison of erysipelas often escapes from the system through the agency of a bronchorrhoea or otorrhoea, thus preventing an open attack of the disease. Nurses and others exposed in an erysipelas ward have frequent attacks of this description.

We are far from believing that the mucous membrane is always involved in attacks of erysipelas. Upon the contrary, we have seen many cases in which the disease was apparently confined exclusively to the skin. It may, however, be stated as a law, that attacks originating primarily from, or by extension involving mucous membranes, are much more serious in their nature than those attacks located in the skin or cellular tissue.

We have never seen the constitutional symptoms aggravated by an extension of the inflammation over a large surface of the cuticle, so long as the skin alone suffered from the attack. Large suppurating abscesses are more rare in such cases, at least among those patients coming under our observation. In fact, there is but a small zone of skin in which active inflammatory action exists. As the red wave advances in its march over the skin, *pari passu*, the inflammation behind fades out. Hence there is a division of labor. Before the inflammation exists in any one locality sufficiently long to produce disintegration, another part becomes involved. It may be stated as a general law, that in those cases in which the nervous symptoms predominate over the vascular, the tendency to death is much greater. Such cases often bear a striking resemblance in some of their leading symptoms to typhoid fever. The coma is sometimes very deep. It is hard to fix the attention of the patient. Sometimes the reverse obtains, and a wild delirium is exhibited. The patient will jump from his bed, and endeavor to run about the ward. The tongue and teeth are usually covered with glutinous black sordes, which sometimes require considerable trouble to remove. From such symptoms an unfavorable prognosis may be generally surely given. Costiveness has always proved to be a favorable condition in this hospital. Patients who were costive during the disease but rarely died.

Secondary and tertiary attacks of erysipelas are of frequent occurrence in our hospital. Whether these attacks are the result of fresh contagion, or the responses of some of the old poison still lingering in the system, are questions yet *sub judice*. These attacks rarely cause much constitutional disturbance. They are most generally confined to the skin, seldom dipping down into the cellular tissue. The attack rarely lasts more than three or four days.

Treatment.—So many contradictory opinions are held in the profession in regard to the nature and cause of erysipelas, that it is not strange that an equally vacillating treatment should be pursued. We are recommended by

some to bleed the patient profusely in the beginning of the attack; to open the bowels and arouse secretion by a large dose of calomel. We are told that by pursuing this course of treatment the disease may be often averted. We do not know; we have never tried the treatment, and never will, unless our ideas in regard to the disease should undergo a radical change. We apprehend that no one ever averted a case of erysipelas by such a course of treatment.

The question presents itself—Can any good be accomplished by depletion? Were we influenced alone by the authority of names, this might be a difficult question to decide. Venesection has been highly extolled as a remedy in erysipelas. Some have gone so far as to assert that if timely brought into requisition the disease might be averted. This treatment, as we have already remarked, cannot accomplish such a consummation. It is irreconcilable with the modern idea in regard to the nature of the disease. It is to all intents and purposes a self-limited disease, depending upon a poison that in some way fastens upon the system. The fever is not symptomatic, as many have contended of the external inflammation, but, as in the idiopathic fevers, a morbid result of the impress of the poison upon the system. The disease is manifestly one of those that tend to a rapid destruction of the vital powers—Why still further lessen the chances of recovery by bloodletting? One or two applications of the lancet cannot change the morbid condition of the blood left in the system, or prevent the formation of more of the same character. Our ideas should be directed to an alteration of the whole quantity, and as this idea cannot be carried into practical effect by means of any known drug, we treat the disease as we would any other self-limited fever—*watch it*, and support the patient.

We should reject emetics in the treatment of erysipelas upon the ground that they tend to prostrate the patient, and can be of no possible benefit.

Purgatives are liable to the same objection, and, further, that they increase the already irritable condition of the intestinal mucous membrane. We have already stated that our costive patients almost without exception recovered; hence, we have been slow even to administer aperients, lest we should produce in the patient a condition unfavorable to recovery.

Muriated tinct. of iron, so highly approved by the profession, has utterly failed to accomplish any good in our hands. We gave it in ten drop doses every two or three hours. One surgeon remarked to us that he gave forty drops every two hours in cases coming under his charge, and attributed its failure in our hands to the fact that we gave an insufficient quantity. We finally concluded to stop its use for a few days. Our patients did better—there was less disturbance of the bowels and stomach. Latterly we have not used it at all. Before abandoning its use, however, we gave it a fair trial.

Quinine, we believe, is positively hurtful; to say the least, it has never benefited our patients, unless a malarial diathesis existed.

Local Treatment.—We commenced treating erysipelas in this hospital with the firm conviction that the topical application of the tinct. of iodine or nitrate of silver would not arrest the spread of the inflammation. Subsequent experience has demonstrated to us that the latter may limit its progress. We have already said that our observations held us out in the opinion, that the diffusion of the inflammation over a large surface of the skin was not absolutely hurtful. We have also stated that, in our opinion, the great danger in erysipelas lay in its involvement of some vital organ. Hence we have doubted the propriety in many cases of arresting the outward signs of the disease. No one would think of arresting the eruption of measles, scarlatina, or small-pox, and the question naturally presents itself—What beneficial results do we gain by stopping that of erysipelas? We have never been able to decide this question from observation. We strongly incline, however, to the opinion,

that the application of these remedies will be finally abandoned by the profession.

In our treatment of erysipelas in this hospital, we have long since abandoned the idea of any specific remedy, and base our principal hope for recovery upon supporting the strength of the patient until the disease shall have spent its force. We have the wards constantly well aired. Disinfectants are also freely employed. We have the floors of the wards thoroughly scrubbed four times a week, and enjoin a frequent change of linen. In addition, we watch the advent of any untoward complication. We have found wine and brandy two of our best supportives. The greatest attention should be given to the patient's diet. Milk, eggs, corn bread, butter, tender beef-steak, beef-tea, potatoes, etc., should constitute the principal food used. We have also been in the habit of letting the patients use canned fruit freely.

As a topical application, solution of plumbi acet. is very grateful. We frequently use collodion. Unsalted pig's lard is a very fine application.

When an abscess forms, the pus should be immediately let out by free incisions. Also, extensive infiltrations of serum in the cellular tissue should be evacuated.

Progress of Medical Science.

ON THE USE OF NITRIC ACID IN THE CURE OF ULCERATION OF THE OS AND CERVIX UTERI.

PREPARED BY E. H. JAMES, M.D.

The treatment of ulceration of the os and cervix uteri by the local application of pure nitric acid is not altogether new, but is employed freely by some successful practitioners of this and other cities. The subject, however, has received a strong confirmation in a communication to the *British Medical Journal*, by Mr. HAMMETT HAILEY, formerly house-surgeon to the Midland Counties Lying-in Hospital, which is of sufficient interest to deserve the attention of those who have never tested the employment of this well known powerful agent. The cases reported by him he divides into two classes:—1. Cases of cancerous ulceration, or disease with apparent malignant tendency, where the ulcer is large, excoriated, discharging pus or matter of a muco-purulent character, in conjunction with great derangement of the general health; in fact, every symptom of cachexia. 2. Cases of simple ulceration or excoriation, with or without hypertrophy, accompanied by symptoms not quite so distressing to the general health. The first case reported occurred in the year 1850. The patient for fourteen months had been gradually losing flesh, with pains in the back, sickness, loss of appetite, perspirations, constipation, and slight cough. She had been treated for pulmonary disease by a private practitioner, and had undergone a digital uterine examination in a neighboring infirmary. On examination with the speculum, the uterus was found prolapsed, and the os imbedded in a mass of muco-purulent discharge (although the patient used daily alum injections), on the removal of which, both labia of the os uteri were found extensively ulcerated some distance up the cervix. Prescribed liberal diet, vegetable tonic with iodide of potassium, and local application of nitrate of silver. At the end of two months, there being little or no improvement, both the local and general treatment were changed. The ulcerated parts were first washed with a moist sponge and freed from all discharge, and the diseased portion then painted with pure nitric acid, and the speculum retained *in situ* for half an hour, for the purpose of preventing the acid from injuring the adjacent parts. She was also directed to take twenty minims of the tincture of the sesquichloride of iron twice a day. At the expiration of a fortnight the excavated portions of the ulcer were found quite filled up, and the whole disease presented a healthy appearance. The acid was again applied, and the same treatment continued for

about two months, when the patient's health was quite restored. Three years afterwards she was confined with her seventh child, when no symptom of uterine mischief was present, neither did there appear any cicatrix to interfere with the proper function of the os uteri. Other cases of the same kind are reported, together with a number of a more simple nature, all showing the superiority of this to other applications. The use of the speculum is defended, and the benefit derived from it illustrated in the report of a case of about two years' duration, attended with great emaciation, vomiting after meals, cough, loss of appetite, diarrhoea, fainting upon the slightest exertion; and every symptom of cachexia. This patient had undergone digital examinations, and consumed gallons of injections of lead and alum; yet, on examination with the speculum, the vagina appeared red and inflamed, the os uteri was incased in a layer of thick muco-purulent matter, on the removal of which, the labia of the os could not be defined, but the whole cervix appeared one mass of ulcerated disease, bleeding upon the slightest touch, yet she recovers strength, and is restored to her original health and vigor so as to be able to pursue her usual occupation, that of a washerwoman. Taking for his text a remark of Dr. Bennet, that "the only treatment to be depended upon, is one of such stimulation of the ulcerated part as to modify its vitality in such a manner as to induce a healthy action, and finally cicatrization," he reviews briefly the merits of the various substances hitherto used for that purpose. The nitrate of silver, though for a long time the favorite in general practice, and in a majority of instances used successfully, is still very uncertain, and requires constant repetition, very much to the annoyance of the patient and to the dissatisfaction of the surgeon. He objects to the actual cautery and potassa fusa on account of the great constitutional irritation often attending their use, while he is unwilling to add to the repugnance that women already have to the use of the speculum, by the addition of the electric battery to that delicate region. He disposes of injections in a few words, as being in a great majority of cases only vaginal, hardly ever reaching the os uteri, and useless except as cleansers of the vagina, or for affording temporary relief in the form of an opiate. He speaks of the acid nitrate of mercury as a valuable remedy, but one that requires a greater number of applications than the pure nitric acid. In cases of cancer of the uterus, when the stage of ulceration has commenced and hæmorrhage made its appearance, the acid will be found the safest and most styptic application for arresting its progress. It is applied with a glass brush all over the diseased os, and allowed to penetrate its cavity; the speculum is retained until every chance of the adjacent mucous membrane being touched is over, and on its removal the vagina plugged with wool. The application may be repeated once in ten or twelve days until the cure is effected. Three things are necessary to effect a cure, viz. a full view of the diseased surface, supporting the general health, and the application of a powerful escharotic, touching the external portion of the os uteri, and dipping full into its cavity. "Armed with the tincture of the sesquichloride of iron as an internal, and the pure nitric acid as an external remedy, the practitioner need never despair of fulfilling these intentions."

THE IODINE TEST FOR DIABETIC URINE.—The value of the iodine test for diabetic urine, as proposed by M. Trousseau, has been disputed. It appears, in fact, that healthy urine decolorises iodine when added to it, only it does so less rapidly than diabetic urine. It would appear, from observations made by M. Corvisart, that the decolorising of the iodine tincture depends chiefly upon the action of the uric acid and the urates in the urine; and, consequently, that the decolorising power of the urine, whether diabetic or not, is measured by the relative quantity of these salts in the urine. If it is demonstrated that this power resides preeminently in diabetic urine, it will then be necessary to learn the relative quantity of those salts which are contained in it.—*British Medical Journal*.

FOREIGN CORRESPONDENCE.

LETTER XXXVI.

By PROF. CHARLES A. LEE.

VENICE, AS A RESORT FOR INVALIDS, ITS TOPOGRAPHY, PHYSICAL HISTORY, HEALTHINESS, ETC.

VENICE, Oct. 15th, 1862.

WE have seen that the Queen of the Adriatic is a compact city, built on piles in the midst of a lagune, on nearly a hundred mudbanks just rising above the surface of the water, divided into two parts by the Grand Canal, which is crossed by three bridges only, the Rialto of stone, the others iron: each part made up of many small islands, and these islands again separated from each other by canals (*rii*) running in every direction, and crossed by several hundred very narrow and steep bridges, cut into easy steps, so that the foot-passenger, in finding his tortuous way along the many foot-paths (for they can hardly be called streets) from one part of the city to another, is constantly going up and down flights of steps, the Rialto being the highest, as it is also the steepest. Having spent many days in a gondola exploring these canals and the many palaces and buildings fronting upon them, I found it impossible to overcome the feeling of sadness which involuntarily creeps over the mind, as the memory of its past glory and magnificence contrasts its former splendor with its present ruin and decay. Not in a single instance did I hear the song of the gondolier, nor scarcely any sound, except, occasionally, his strange, warning cry, "Ah, ch," as he turned the sharp corner of one canal or street into another; no recitation of Tasso's verses; no loud talk; no laughter; no ladies on the balconies, nor heads at the windows; no curiosity to see who or what was passing. A melancholy silence brooded over all, while a grim, stern, savage, defiant expression of features seemed the predominant characteristic of the entire native male population. The iron rule of the Emperor Joseph is either expatriating the citizens or driving them to despair, desperation, or madness. To see this proud city, its once handsome marble palaces literally "crumbling to the shore," now occupied as government stores, casernes, offices, or let out to strangers; attempts at restoration or repair, few and far between; its ancient nobility and patrician families extinct, or represented by beggars, it is impossible to check the inquiry—What has produced this mighty change? Has it been physical, or moral and political causes? To be satisfied of the latter, we need not search the 8,664,000 volumes and portfolios constituting the archives of Venice in the Convent of the Trani, or the 65,000 volumes and 5,000 manuscripts in the Great Council-Chamber.

The Venetians, though of a bilio-nervous temperament, easily excited and easily depressed, have lost much of the ardor, courage, and enthusiasm which formerly characterized them as a nation. From some cause or other they have sunk down into a very ordinary, commonplace kind of people; but its historical associations, the topography and peculiarities of the city, will always attract strangers to the spot, and render Venice one of the most interesting cities of the world.

It has been remarked that there seems to be a mysterious attraction between hectic patients wandering after an *ignis fatuus*, and various desolate and woe-begone cities in the south of Europe, as Pisa, Rome, and Venice. I can testify that, so far as the latter city is concerned, the remark is literally true. It is now early in October, and already many English and some American invalids, with pulmonary symptoms, have taken lodgings here for the winter, the chief attractions being the mildness and equability of the climate, and the belief, sustained by the chemical researches of Cenadella and Pisanello (1847), that the air is impregnated with emanations of *iodine* and *bromine*, so generally recommended in this class of affections. The native as well as foreign physicians, resident here, magnify these advantages, overlooking the well known fact that tuberculosis is one of the most common and fatal diseases amongst

the native inhabitants. But then the magic of its name, its romantic history, its splendid ruins, and its galleries of paintings and sculpture, have also great influence in attracting invalids hither; and I have seen patients in every stage of consumption, to whom *change of scene* has been recommended as of equal importance as change of climate, impelled by a morbid curiosity or a contagious sight-seeing mania, seeking out, from morning till night, the works of Titian; the frescoes of Tintoretto and Paul Veronese; the statues, palaces, temples, and mausoleums of Sansovino and Palladio; or those horrible, damp, dismal, dark dungeon cells, the Piombi and the Pozzi, in the vaults of the Ducal Palace, over which the boats on the canal pass, and with whose history so many tales of horror are connected. Now, though I fully believe in the value of change of scene in pulmonary diseases, I cannot subscribe to the benefits of roaming at all hours about old, damp ruins, cold churches, long picture galleries, empty palaces, or any other places where the air is likely to become stagnant or impregnated with noxious exhalations. A connoisseur in bronzes, pictures, statues, and architecture, or the antiquary trying to decipher half-worn inscriptions on the mouldering walls of some ruin or dungeon, will not be very likely to pay much attention to the climate and atmospheric conditions by which he is surrounded. I have known two Americans, in the last stage of phthisis, spend many successive hours, standing on the cold sunken floor of the basilica of St. Mark, breathing its damp and impure air, examining the mosaics, sculptures, basso-relievos, and arabesques with which it is profusely ornamented; or the gilded arched roofs, the pavement of jasper and porphyry, the five hundred columns of black, white, and variegated marble, of bronze, alabaster, verde-antique, and serpentine, unconscious at the time of suffering or fatigue, but at an expense of vital force which it required many days to repair. The mild, balmy air of Venice, so soothing, and apparently healing in its influence; the freedom from dust; the gentle, sleep-provoking, gondola exercise, so particularly adapted to consumptive patients; the abundant markets, supplying almost every variety of fish, flesh, and fowl; the bright skies, and freedom from noise, all these are advantages which cannot be disputed; but it is questionable whether they are not counterbalanced by the evils already mentioned.

A city built on a group of mudbanks, in the midst of a lagune, surrounded with swamps and marshes, would seem to be not very favorably situated for health or pleasantness. But notwithstanding the offensive effluvia from some of the canals during the heats of summer, I cannot learn that there is any great amount of sickness. Intermittents, of not a very severe grade, are not uncommon in spring, and in August, September, and October; but epidemic fevers rarely if ever prevail. The periodical fevers, I am told, have not the malignant character of agues arising from ordinary marsh malaria, and seldom leave, as sequels, enlargement of the spleen or liver. No doubt they are caused by the exhalations from the canals, though some physicians here believe they are mainly produced by the great difference of temperature between day and night, acting upon constitutions relaxed by summer heat, and the humid condition of the atmosphere. They are far more prevalent in the islands than in Venice itself. Although bleeding is so generally practised, inflammatory diseases are singularly mild, and combined with much nervous irritability. I am surprised to find so great a prevalence of nervous and convulsive affections, both in males as well as females, and among all classes, high and low. The causes are, doubtless, to be sought for chiefly in the peculiarities of the climate, aggravated by the indolent and inactive habits of the people acting on nervous temperaments. Hence also the great frequency of pulmonary and scrofulous complaints, which generally take on a very chronic form. Apoplexy is a very common disease, and ossification of the arteries frequently met with. Hernie are extremely common, owing to the relaxing influence of the humid climate; and owing to the same cause, wounds and ulcers heal slowly.

We should suppose, *a priori*, that exhalations from the numerous canals in summer and autumn would create a great amount of sickness, but such is not the case; as they are generally very narrow, deeply incased between the walls of the houses, and their muddy bottoms scarcely ever exposed to the atmosphere. Besides this the tide ebbs and flows twice a day, carrying out organic matters far into the Adriatic, so that little miasma can be formed from decomposition, and then the great prevalence of north-east winds carries away from the lagune any unhealthy emanations which may exist in its vicinity. The topography of Venice must be studied in connexion with its climate, and both as related to its salubrity. What is called the *lagune*, in which Venice is situated, lies at the north-west extremity of the Adriatic, is of an oval form, about thirty-three miles in its greatest diameter from north-east to south-west, and from six to twelve miles in its other diameter; being bounded from the north-east to the south by the main land, and from the latter a strip of land extends north with some interruptions so as to cut off all communication between Venice and the sea except by their openings. The *Lido* or maritime boundary is thus formed by a series of small islands, on the eastern aspect of which are the *Murazzi* or great sea walls, the object of which is to protect the long sandy spits that separate the lagune from the Adriatic from the inroads of the latter. They consist of a great embankment of huge blocks of Istrian stone, rising eighteen feet above high water, presenting an inclined surface outwardly or in the form of stairs: the whole length of the *Murazzi* is about three miles and a quarter. They were commenced in 1741 and completed in 1782. The width of this pyramidal structure at its base on the level of the sea is forty-five feet. These openings between the islands serve the purpose of sluices, always free, through which the waters ebb and flow daily. The cold winds from the Julian and Carnatic Alps thus sweep across the north-east extremity of the lagune, which is not much sheltered against their influence, if at all; and as these winds are the predominant ones, they tend greatly to scatter any noxious exhalations which may be found. The more elevated Alps on the north serve to shelter the city to a great extent against the northerly winds, while the mountain range which skirts Lombardy serves also to shield it in a great degree against the west and south-west winds. The only winds which have full sweep over the lagune are the Sirocco or south-east, and the east, coming from the sea. The winds which principally influence the climate of the lagune are, thus, the north-east, the east, and the south-east; the north and the west being the least frequent, owing to the barrier caused by the elevation of the central Alps and the adjoining summits. Now, besides the small canals which I have mentioned, there are three large canals, the *Giudecca*, *Canale Grande*, and *Canale Regio*, intersecting the city in different directions, so that both land and sea breezes traverse the whole extent of the city without interruption, thus securing a free circulation of air, and contributing greatly to the salubrity of the place.

Meteorological tables kept by the *Athenaeum* of Venice show that the mean temperature of winter is 38° F., that of spring 56° F., that of summer 72° F., and that of autumn 56° F.; the annual mean is 56° 75' F. At Padua, the winter mean is 36° F., and that of Milan is 34° F. It is admitted that Venice is the warmest medical station on the Adriatic coast of Northern Italy, and that the temperature rises as we approach the sea, and falls in proportion as we advance towards the foot of the Alps. And what is still more important to the invalid, the variations of temperature between the mean maxima and minima at Venice are on a much more limited scale than in the principal towns of Northern Italy, and even many places in the South. For example, the variations in the winter season are only 52°, whilst at Padua they are 56°, at Milan 55°, at Pavia 60°, at Florence 59°, at Rome 59°, and at Palermo the same; a range of from four to nine degrees in favor of Venice*. There are

no sudden transitions, either, between the different seasons, and the variations during the spring, summer, and autumn, are nearly the same in each season, viz. 57°. It is this favorable distribution of heat throughout the year that places the Venetian climate, in this respect, before most other southern climates.

American Medical Times.

SATURDAY, JUNE 6, 1863.

ARMY MEDICAL INSPECTION.

ONE of the most important features in the organized Medical Department of the Army was the Bureau of Medical Inspection. The progress of the science of military hygiene has led other nations to establish a corps of inspectors, whose duty it is to visit camps and hospitals, with the sole purpose of improving their sanitary condition. The most marvellous improvement in the health of armies has followed the inauguration of a system of rigid sanitary surveillance. During the late war in China the English troops maintained, even in unhealthy districts, a better average of health than the people of England at large. With the organization of our immense armies it became a matter of the very first consequence that a similar system of sanitary inspection should be established in connexion with the Medical Department. An act was duly passed into a law creating such a Bureau with ample powers. The success of this scheme depended primarily upon the organizing and executive force of the chief officer; and secondarily upon the efficiency of the corps of inspectors. The appointments were to be made by the President and Senate, and it became a matter of great interest to determine who should be selected for these positions. Of course political influence entered largely into the canvass, but did not materially affect the result, except in the selection of the Inspector-General. To the surprise and mortification of the true friends of the public medical service, the whole question of qualification in his case seemed to be set aside, and mere political availability alone consulted. The person appointed was unknown to the profession. To the inquiry as to the antecedents of the appointee, no information was elicited. It was rumored that he had a friend at Court, and that the appointment was a political *quid pro quo*, or one of those arbitrary selections of officials without regard to the public interests with which the secret history of every administration abounds.

It was feared that the whole scheme of sanitary inspection had been seriously compromised and perhaps sacrificed by the selection of an incompetent executive officer. When it was recollected that medical men of the very highest qualifications were placed prominently before the appointing power, and that their claims were ignored, though the Act provided expressly that the selection should be made solely on account of merit, great and justifiable indignation was felt at the manner in which the public interests were trifled with. Still, there was a strong disposition manifested to withhold criticism, and give the new organization a fair trial.

(for twenty-one years) is 120°; the mean monthly range 67° 5'; and the mean annual range 100°; annual mean 48°; highest degree 91°; lowest degree 23° F.

* At Albany, U.S., N. Lat. 42° 30', the extreme range of temperature

A year has passed, and we are now able to form an intelligent judgment of the success of this department of the medical service of the army. The corps of medical inspectors have, in general, faithfully and intelligently performed the duties assigned to them. Camps and hospitals have been regularly visited, and reforms have been instituted and abuses corrected. Valuable reports have been made, which might serve as the basis of perfecting the organization of this system of inspection, and give completeness and efficiency to all its details. But they are lost to the Bureau itself. Its chief executive officer, the MEDICAL INSPECTOR-GENERAL, has, as was anticipated, proved to be destitute of those qualifications necessary to its proper organization and direction. His administration of its affairs has proved a wretched failure. He has not comprehended the true design of the service, and of course has not given it proper scope or direction. As in other branches of the public service where the demon of politics has dictated the appointment, so in the Sanitary Bureau imbecility is the chief characteristic of the highest official. Practically, indeed, the department of medical inspection does not exist, as the INSPECTOR-GENERAL is not, we believe, recognised by his superior officers, and the corps of inspectors is under the immediate direction of the SURGEON-GENERAL.

It is exceedingly painful to be under the necessity of reflecting so severely upon a medical officer occupying a high and responsible public position. But the interest which the profession has felt in the success of the system of sanitary inspection of the army compels us, as journalists, to expose the character of its chief medical officer, and comment with due severity upon his official conduct. We are far, however, from pronouncing this organization for medical inspection a failure. Through the enlightened zeal of the individual members of the corps, and under direction of the SURGEON-GENERAL, great good has been accomplished. The comfort and health of the troops in every section of the country have been largely promoted by the wise counsel of the inspectors' corps. But the full measure of usefulness of this branch of the medical service can never be realized until a competent and energetic executive officer shall give proper scope and direction to its details.

THE WEEK.

THE "Soldiers' Home," an institution chartered by the last Legislature of New York, has been organized by the appointment of a Board of Trustees. We learn that the Trustees will meet at once and take measures to raise funds. It is estimated that two hundred thousand dollars can be raised by private subscription. It is proposed to establish an institution, which, for the soldiers of the State of New York, shall supply the place of the Hotel des Invalides in France, and the Chelsea Hospital in England. The act of incorporation states the object of the institution to be, to provide "a home and maintenance for officers and soldiers who have served, are serving, or may hereafter serve, in the volunteer forces raised or furnished by or from the State of New York, who by reason of wounds or other disabilities received or produced in the service of the United States, or of the State of New York, shall be unable to support themselves, and all who, having been honorably discharged, shall be decrepit or homeless in their

old age." The flags of the different regiments, on their return from the war, are by law to be deposited in the Home. The institution is to be managed on military principles. The practical management is to be intrusted to officers and soldiers who have received an honorable discharge, preference being given to those partially disabled. The citizens of Auburn have tendered a site not exceeding 300 acres in extent, provided the institution is located there.

QUEEN VICTORIA and some members of her family have recently visited a hospital, and the English Journalists express their admiration of this act in the most extravagant terms. The QUEEN seems to have manifested an interest in the arrangements of the hospital, and inquired in regard to them, and even spoke to several patients. "She was very gracious, and her voice was beautifully clear and sweet." *** "PRINCE ALFRED looked quite strong and robust." *** "The PRINCESS ALICE spoke to several of the soldiers' wives." *** "PRINCE LOUIS also seemed both interested and pleased." Such royal condescension has justly astonished the English nation. But in this country we regard such courtesies paid by the Ruler to the soldiers as but a duty, and unworthy of comment. We have seen PRESIDENT LINCOLN passing from bed to bed in our military hospitals, and greeting the soldiers with a hearty shake of the hand. There was nothing in the act to excite our astonishment; nothing in his personal appearance or voice to excite our admiration. It is probable that MADAME VICTORIA and FATHER ABRAHAM will appear at about the same advantage in the respect which they showed to the soldiers of their respective Governments on the page of impartial history.

THE profession will learn with much gratification of the selection of PROF. ALDEN MARCH, of Albany, New York, as President of the American Medical Association for the ensuing year. Fears had been entertained that, through improper influences, a person might be selected to that position unworthy of the confidence of the profession on account of his disloyal proclivities. But we are now relieved of all apprehension, and we welcome the election of PROF. MARCH as the best evidence that the Association is to continue its career of usefulness with undiminished vigor and influence. We must congratulate PROF. PERCY, of this city, on the honor of obtaining the prize of the Association for his essay on *Veratrum Viride*. It will prove some compensation for the time and labor which he has expended in the experimental investigation of the properties of this agent.

It is with unfeigned regret that we announce the death of DR. JOHN WATSON. To his personal friends his death was not unexpected. He has long suffered from malignant disease of the rectum, which compelled him to retire from business several months since, and finally proved fatal on Wednesday, June 3d. DR. WATSON has long occupied a prominent position in the profession, both as a writer and practitioner. His loss will be seriously felt by his numerous friends and associates.

AMERICAN MEDICAL ASSOCIATION.

FOURTEENTH ANNUAL CONVENTION, held in the City of Chicago, June 2d, 3d, and 4th, 1863.

THE Fourteenth Annual Convention of the American Medical Association commenced in this city to-day. At the opening of the session 141 gentlemen were in attendance. It is expected that the medical skill of the country will be ably represented, and that the session will be one of unusual interest and practical value in its relation to the sanitary wants of the country. The meetings are held at Bryan Hall. The opening session was called to order at eleven A.M. by the first Vice-President, Dr. Wilson Jewell, of Penn., supported by Vice-President Dr. A. B. Palmer, of Michigan. The Secretaries, Drs. S. G. Hubbard, of Conn., and H. A. Johnson, of Illinois, were also present. Prayer was offered by the Rev. R. L. Collier, pastor of the Wabash avenue M. E. Church.

The welcome address was delivered by Dr. N. S. Davis, of this city, Chairman of the Committee of Arrangements, to the following effect. Dr. Davis welcomed the members to the city of Chicago. They had heretofore met in cities at the East, where years of improvement had wrought more perfections than in Chicago, but here were all things pertaining to those cities in their incipency. He could point to our great granaries, our great commercial interests, our schools, our universities, and our every element of civilization, where recently the Indian and untutored life was rife, with pride. New as Chicago is, she is not behind the age. The same patriotism, friendship, and harmony of interests exist, and he welcomed them to all the hospitality which Chicago could afford.

Which address was followed by the following report of the Committee of Arrangements:—

The unusual duties and responsibilities which have devolved upon the committee, since the meeting at New Haven in 1860, seem to require a brief explanation, in addition to the usual report, on this occasion. Early in the year 1861, the usual notices for the regular meeting on the first Tuesday in June, of that year, were issued, and the committee had made all the preliminary arrangements for its accommodation, when the sectional animosity and wickedness which had been threatening the peace of our country for several years, culminated in an open, unjustifiable, and monstrous rebellion. In the midst of the universal excitement which followed, the committee received numerous letters from active members of the Association, some of them embodying the action of local medical societies, all asking earnestly for a postponement of the general meeting for one year. These letters were from every section of the Union, including the cities of Boston, New Haven, New York, Troy, Albany, Philadelphia, Cincinnati, Louisville, Nashville, St. Louis, and Detroit. A special meeting of the committee was held, and all these letters, together with similar sentiments expressed in the medical periodicals, were submitted for examination.

Although there is nothing in the constitution or by-laws of the Association, authorizing either the officers or the committee of arrangements to postpone a regular meeting, yet the extraordinary condition of the country, and the apparent unanimity of sentiment in favor of such action, constrained the committee reluctantly to issue a notice that the annual meeting would be postponed until the first Tuesday in June, 1862. About the time for issuing the notice for the meeting in 1862, the severe battles of Belmont, Fort Donelson, and Shiloh, followed each other with such results as to require the attention and active assistance of large numbers of the profession in the north-west, and at a meeting of the committee the chairman was instructed to correspond with members of the Association in the several cities heretofore named, and obtain further advice before issuing any notice. The instructions were complied with, and of a large number of letters received in reply, all but two earnestly recommended another postponement. At a subsequent meeting the committee being satisfied that these letters afforded

a fair index of the sentiments of the profession generally, unanimously instructed the chairman to issue notices, announcing a further postponement of the meeting until the first Tuesday in June, 1863. These successive postponements were fully endorsed by almost every medical journal in the country. No further action was taken by the committee until February, 1863. On the thirteenth of that month the chairman of the committee received official notice from the secretary of the Medical Society of the State of New York, that at the regular annual meeting of the Society held in Albany during the first week in that month, a resolution had been adopted unanimously in favor of holding a meeting of the American Medical Association at the regular time and place, specified in the last notice of postponement, namely in Chicago, on the first Tuesday in June, 1863, and requested the committee of arrangements to issue the customary notices for such meeting without delay.

About the same time the AMERICAN MEDICAL TIMES in New York, and the *Medical and Surgical Reporter* in Philadelphia, strongly recommended the same course of action. The committee was convened on the evening of the 14th of February, and being satisfied that the foregoing action of the New York State Medical Society, and of the medical periodicals named, indicated a general change of sentiment in favor of resuming the regular meetings of the Association, a vote was passed unanimously instructing the chairman of the committee to issue the usual notices for the annual meeting of the Association, and to engage the necessary hall for its accommodation. Accordingly notices were immediately printed, and before the 1st of March copies had been mailed to all the medical periodicals in the country; to all the members of committees, both standing and special; and to many other members of the Association. The committees have been gratified to find that the call for the present meeting met the warm approval of nearly all the medical periodicals in our country, while in only one have they observed a decided expression of disapproval. Whether the action of the committee has been right or wrong, judicious or injudicious, we know that it has at all times been actuated by one single desire, namely, to comply with the actual wishes of the profession, and to perpetuate the existence of the Association with ever increasing activity and usefulness. In the spring of 1861 persevering efforts were made by the committee to effect an arrangement with the several important railroad lines to make some commutation of fare to such members as should attend the proposed meeting of the Association in this city. During the present season, these efforts were repeated, but in both instances the uniform answer of railroad officers was: that they were prohibited by direct conventional agreements, from entertaining any proposition of the kind. The committee have been informed that at a meeting of railroad officers in Buffalo, on the twenty-ninth day of April last, such influences were brought to bear as caused them to make the *canal enlargement convention*, now in session in this city, an exception to the rule against commutation of fares, while all other applications for the same purpose were denied. For further information on this subject, the committee refer to an announcement which will be made at an early hour by the local secretary of the Association. Notwithstanding all the disagreements which have existed, the committee are happy to announce that the number of delegates and permanent members whose credentials have already been furnished, and their names enrolled, is such as to indicate a large and profitable meeting. The list of names will be read at the calling of the roll by the secretary.

In conclusion, the committee recommend, that after the adjournment of the meeting this afternoon, the sessions of the Association be continued each day as follows:

General session from 9 A.M. to 1 P.M.

Afternoon sessions in sections from 3 P.M. to 6 P.M.

Seats will be reserved in the gallery for ladies during all

the general session in Bryan Hall. All of which is respectfully submitted.

Signed
N. S. DAVIS,
THOS. BEVAN,
E. ANDREWS,
H. W. JONES, } Committee.

DR. CATLIN, of Connecticut, moved that the report be accepted and approved, which was carried.

The Secretary, Dr. Hubbard, of Connecticut, called the roll of delegates and permanent members, who had registered their names, only a very few being absent.

VERMONT.—Drs. J. N. Stiles, Lewis Emmens.

MASSACHUSETTS.—Drs. Benj. Cutter, Appleton Thorne, Edmund Barton, Jas. P. Lynde, Ebenezer Stone, P. J. Kendall, B. E. Cotting, John Homans, John C. Dalton, M. D. Southwick, E. R. Abbe, John Green.

CONNECTICUT.—Drs. Stephen G. Hubbard, L. N. Beardsley, R. H. Catlin, A. W. Barrows.

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KANSAS.—Drs. D. W. Stormont, C. A. Logan.

TENNESSEE.—Dr. W. K. Bolinz.

ARMY AND NAVY DELEGATES.

Dr. C. C. Cox, Baltimore, Med. Dept., U.S.A.; Dr. G. Simpson, Baltimore, Med. Dept., U.S.A.; Dr. A. R. Terry, Chicago, Med. Dept., Marine Hosp.; Dr. John B. Porter, Chicago, Pension Office Examiner; Dr. Henry Palmer, York, Penn., York Army Hosp.; Dr. M. K. Taylor, Keokuk, Iowa, Gen. Hosp.; Dr. Ralph Isham, Chicago, U.S. Hosp.

DR. H. A. JOHNSON, one of the secretaries, invited the delegates to attend the National Canal Convention, now in session in this city, and thereby obtain free tickets home.

Here a recess of ten minutes was allowed for each State to nominate a delegate, and constitute the committee on nomination.

The following gentlemen were chosen on the nominating committee:—Drs. J. N. Stiles, Vermont; John Homans, Massachusetts; L. N. Beardsley, Connecticut; James McNaughton, New York; John Blain, New Jersey; H.

F. Askew, Delaware; W. S. Battles, Ohio; Jas. F. Hibberd, Indiana; Wm. Mayberry, Penn.; H. O. Hitchcock, Mich.; D. W. Stormont, Kansas; John C. Hupp, Virginia; J. H. W. Baker, Iowa; H. Van Duzer, Wisconsin; H. Noble, Illinois; W. K. Boling, Tenn.; C. C. Cox, Maryland.

DR. JOSIAH SIMPSON was chosen in behalf of the U.S.A. On motion of DR. N. S. DAVIS, of Ill., the Acting President, DR. JEWELL of Penn. read his Annual Address on retiring from office.

The following officers were elected for the ensuing year—President, Alden March; Local Secretary, Guido Furman. Committee of Arrangements: Drs. Henderson, Blakeman, Markoe, Finnell, Flint, Arnold, Griscom.

The next meeting will be held in New York.

Army Medical Intelligence.

REPORT OF THE NUMBER OF BEDS

OCCUPIED BY THE SICK, NUMBER OF VACANT BEDS, AND TOTAL NUMBER OF BEDS, IN THE U.S. GENERAL HOSPITALS, FOR THE WEEK ENDING MAY 9, 1863.

LOCALITIES.	OCCUPIED.	VACANT.	TOTAL.
Department of Washington.....	7,964	6,126	14,090
Baltimore District, Middle Dept.....	3,941	6,623	10,564
Philadelphia ".....	3,880	7,916	11,746
Department of the East.....	3,853	5,947	9,800
Department of Virginia.....	1,172	678	1,850
District of Western Virginia.....	776	563	1,339
" Ohio.....	2,146	553	2,699
" Kentucky.....	3,092	2,572	5,664
" Indiana.....	1,161	1,227	2,388
" Illinois.....	1,200	567	1,767
Department of the Missouri.....	2,783	3,951	6,734
" Cumberland.....	5,662	4,542	10,204
" Tennessee.....	2,338	2,055	4,393
" North West.....	544	1,129	1,673
" North Carolina.....	911	384	1,315
" South.....	357	218	575
" Gulf.....	3,176	976	4,152
	44,951	46,042	90,993

It is in contemplation to close several of the hospitals in Baltimore and other cities, particularly those for which the United States is paying high rent.

NAMES OF HOSPITALS.—The General Hospital Ocean House, Portsmouth, Va., has been called the "Balfour" Hospital in memory of Surgeon Balfour, who died in 1830, after thirty-eight years' service in the army and navy.

The General Hospital "Steuart's Mansion," Baltimore, Md., has been called the "Jarvis" Hospital in memory of the late Surgeon N. S. Jarvis, U.S.A., who died while Medical Director of the Middle Department.

The General Hospital Chestnut Hill, Philadelphia, Pa., to be known as the "Mower" Hospital, in memory of the late Surgeon Thomas Mower, U.S.A., for many years Chief Medical Purveyor U.S.A.

The General Hospital, at West Philadelphia, Pa., to be known as the "Satterlee" Hospital, in honor of the eminent, faithful, and meritorious services of Surgeon R. S. Satterlee, U.S.A.

The General Hospital at Fort Schuyler, New York, to be known as the "McDougall" Hospital, in honor of the eminent services of Surgeon Charles McDougall, U.S.A.

The General Hospital at David's Island, New York, to be known as the De Camp Hospital in honor of the long and faithful services of Surgeon S. G. I. De Camp, U.S.A.

Surgeon-General W. A. Hammond, U.S.A., is on a visit to Philadelphia, Pa. Surgeon J. B. Smith, U.S.A., is in charge of the Bureau during his absence.

Dr. G. W. Hogeboom, of Kansas, has accepted the position of Assistant Surgeon of Volunteers, previously declined by him.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 18th day of May to the 25th day of May, 1863.

Deaths.—Men, 108; women, 89; boys, 143; girls, 97; total, 437. Adults, 197; children, 240; males, 251; females, 186; colored, 12. Infants under two years of age, 146. Children born of native parents, 82; foreign, 172.

Among the causes of death we notice:—Apoplexy, 6; infantile convulsions, 85; croup, 2; diphtheria, 12; scarlet fever, 27; typhus and typhoid fevers, 15; consumption, 72; small-pox, 1; measles, 2; dropsy of head, 10; infantile marasmus, 23; cholera infantum, 6; inflammation of brain, 16; of bowels, 10; of lungs, 40; bronchitis, 6; congestion of brain, 0; of lungs, 0; erysipelas, 2; diarrhoea and dysentery, 18. 219 deaths occurred from acute diseases, and 87 from violent causes. 286 were native, and 151 foreign; of whom 90 came from Ireland; 66 died in the City Charities; of whom 20 were in Bellevue Hospital, and 4 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

May 1863	SIX A.M.				TWO P.M.				TEN P.M.						
	Minimum Temperature		Evaporation Below.	Barometer.	Wind.	Temperature.		Evap. Below.	Barometer.	Wind.	Temperature.		Evap. Below.	Barometer.	Wind.
	°	°				°	°				°	°			
17th.	59.64	8	29.96		E.	62	5	29.93		S.E.	60	2	29.54		S.E.
18th.	54.56	5	29.84		N.W.	67	9	29.90		W.	58	6	29.99		W.
19th.	55.58	6	30.03		N.W.	70	11	30.05		N.W.	60	6	30.06		W.
20th.	60.63	7	30.11		N.W.	80	12	30.13		S.	64	6	30.14		S.W.
21st.	63.67	7	30.20		N.W.	83	14	30.13		S.W.	70	8	30.20		S.W.
22d.	65.70	10	30.15		N.W.	87	17	30.17		S.W.	80	9	30.16		S.W.
23d.	54.80	12	30.14		N.W.	77	12	30.07		S.E.	60	6	30.04		S.

REMARKS.—17th, Cloudy; rain P.M. 18th and 19th, Clear, with fresh wind. 20th, Clear; variable P.M. 21st and 22d, Clear. 23d, Clear with fresh wind. Rain for the week one quarter of an inch.

From the 25th day of May to the 1st day of June, 1863.

Deaths.—Men, 84; women, 86; boys, 95; girls, 82; total, 347. Adults, 170; children, 177; males, 179; females, 168; colored, 5. Infants under two years of age, 124. Children born of native parents, 18; foreign, 124.

Among the causes of death we notice:—Apoplexy, 8; infantile convulsions, 24; croup, 13; diphtheria, 9; scarlet fever, 7; typhus and typhoid fevers, 9; consumption, 50; small-pox, 1; measles, 6; dropsy of head, 11; infantile marasmus, 14; cholera infantum, 0; inflammation of brain, 13; of bowels, 7; of lungs, 22; bronchitis, 3; congestion of brain, 13; of lungs, 0; erysipelas, 4; diarrhoea and dysentery, 10. 157 deaths occurred from acute diseases, and 41 from violent causes. 208 were native, and 139 foreign; of whom 97 came from Ireland; 63 died in the City Charities; of whom 23 were in Bellevue Hospital, and 4 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

May	SIX A.M.				TWO P.M.				TEN P.M.			
	Minim. Temperature	Evaporation	Barometer.	Wind.	Temperature	Evap. Below.	Barometer.	Wind.	Temperature	Evap. Below.	Barometer.	Wind.
1863.												
24th.	47.52	4	30.02	N.E.	54	8	30.01	N.E.	50	6	30.00	N.E.
25th.	44.46	4	30.08	N.E.	54	8	30.09	N.E.	46	6	30.10	N.E.
26th.	48.53	5	30.17	Calm.	70	14	30.18	S.W.	55	5	30.14	N.E.
27th.	54.56	6	30.14	S.W.	72	14	30.14	N.	60	5	30.16	W.
28th.	60.65	6	30.15	S.W.	77	15	30.16	S.W.	64	5	30.09	W.
29th.	65.62	6	30.06	S.W.	80	17	30.02	S.W.	70	7	30.00	S.W.
30th.	68.70	7	29.98	S.W.	71	6	29.74	S.W.	69	5	29.71	S.W.
31st.	66.68	7	29.64	S.W.	75	13	29.61	S.W.	68	6	29.60	S.W.

REMARKS.—24th and 25th, Cloudy, with fresh wind. 26th, Light rain, A.M., clear day. 27th, Clear; wind fresh. 28th, Clear. 29th, Clear; fresh wind. 30th, Variable, heavy thunder shower, 2-3 P.M. 31st, Variable, light rain, afternoon. Rain for the week three-quarters of an inch.

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
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